Amherst Health Department / Environmental Health Services
Bangs Community Center, 2nd Fl
70 Boltwood Walk
Amherst, MA 01002
Phone: 256-4033 Fax: 256-4053

PRACTITIONER OF THERAPEUTIC MASSAGE APPLICATION FOR LICENSE

Personal Information: Date:_____

Name:_____Residence:_____
(number & street)

_____
City/Town State Zip Code

Date of Birth:___/___/___ SS# or FedID#_____ Home Tel. #_____
M D Y

Business Information:

DBA:_____
(Either a business name or your own personal name)

Address:_____ Business Phone:_____
(Place of practice)

Name and Address of school attended:_____

Date of Graduation:_____ Hours of Training: _____

Do you have/had a massage license in any other jurisdiction? ___Yes ___No

If yes, list city/towns/states:_____

Was it ever suspended or revoked? ____No ____Yes; explain_____

Are you AMTA certified? ____No ____Yes; Member Number _____
Are you ABMP certified? ____No ____Yes; Member Number _____

If no, give name, address and policy number for personal liability and malpractice insurance.

_____

_____

Signature:_____ Date: _____

FEE: $100.00 annually Original Application ___ Renewal ___

Please list the names, addresses, and telephone numbers of three (3) persons whom we may contact as character references. You must provide an Amherst Board of Health character reference form to each individual listed below. At least one of these persons should live in Massachusetts.

NAME ADDRESS TELEPHONE

_____

_____

_____

I have received and read the Amherst Board of Health "Rules and Regulations for Massage Therapy and Establishments".

Pursuant to M.G.L. Chapter 62C, Section 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state returns and paid all state taxes required under law.

_____ _____

SOCIAL SECURITY NUMBER OR FEDERAL IDENTIFICATION NUMBER

SIGNATURE OF INDIVIDUAL

Please submit a photocopy of your diploma from massage school along with certificates for massage courses successfully completed.

ATTACH PHOTO HERE

CHARACTER REFERENCE

To Whom It May Concern:

_____of_____
NAME ADDRESS

Is an applicant for a license to practice massage within the Town of Amherst. We are requesting your evaluation of her/his character, as she/he has given your name as a character reference. Health Department officials will review your comments.

1. Length of time you have know this individual?

2. In what capacity have you known the applicant?

   Are you related to her/him? _____YES _____NO

3. Please give us your opinion of the character of this person

_____
_____
_____

4. Would you recommend that the applicant be considered for licensure as a massage therapist?
   _____YES _____NO

SIGNATURE:_____DATE:_____

NAME:_____TELEPHONE:_____
(PLEASE TYPE OR PRINT)

ADDRESS:_____

REFERENCE PERSON: PLEASE RETURN THIS QUESTIONAIRE DIRECTLY TO ENVIRONMENTAL HEALTH SERVICES, AMHERST HEALTH DEPARTMENT, AT THE LETTERHEAD ADDRESS.

CHARACTER REFERENCE

To Whom It May Concern:

_____of_____
NAME ADDRESS

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5. Length of time you have know this individual?

6. In what capacity have you known the applicant?

Are you related to her/him? _____YES _____NO

7. Please give us your opinion of the character of this person

_____
_____
_____

8. Would you recommend that the applicant be considered for licensure as a massage therapist?
_____YES _____NO

SIGNATURE:_____DATE:_____

NAME:_____TELEPHONE:_____
(PLEASE TYPE OR PRINT)

ADDRESS:_____

REFERENCE PERSON: PLEASE RETURN THIS QUESTIONAIRE DIRECTLY TO ENVIRONMENTAL HEALTH SERVICES, AMHERST HEALTH DEPARTMENT, AT THE LETTERHEAD ADDRESS.

CHARACTER REFERENCE

To Whom It May Concern:

_____of_____
NAME ADDRESS

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9. Length of time you have know this individual?

10. In what capacity have you known the applicant?

Are you related to her/him? _____YES _____NO

11. Please give us your opinion of the character of this person

_____
_____
_____

12. Would you recommend that the applicant be considered for licensure as a massage therapist?
_____YES _____NO

SIGNATURE:_____DATE:_____

NAME:_____TELEPHONE:_____
(PLEASE TYPE OR PRINT)

ADDRESS:_____

REFERENCE PERSON: PLEASE RETURN THIS QUESTIONAIRE DIRECTLY TO ENVIRONMENTAL HEALTH SERVICES, AMHERST HEALTH DEPARTMENT, AT THE LETTERHEAD ADDRESS.